

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05408

Reg. Dist. No.

5417

1. PLACE OF DEATH a. COUNTY <u>Calvert Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince, Fredrick.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>	
c. LENGTH OF STAY IN 1b <u>pya. 5 month.</u>		d. STREET ADDRESS <u>084-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Nursing Home.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>R.</u> Middle <u>Anderson</u> Last		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert J. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK</u>	
17. INFORMANT <u>Bill Hamilton, Waldorf, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia.</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>May 6</u> , 19 <u>59</u> , and that death occurred at <u>6:40</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>A W Ward</u> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>	22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt &amp; Funeral Home, Waldorf, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>MAY 11 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: *John J. Smith*  
2. Age: *45*  
3. Sex: *Male*  
4. Date of death: *Jan 15, 1910*  
5. Place of death: *Home*  
6. Cause of death: *Heart disease*  
7. Signature of physician: *J. H. Jones*  
8. Signature of registrar: *W. B. Brown*

Witnessed by

9. Name of witness: *John J. Smith*  
10. Signature of witness: *J. H. Jones*  
11. Name of witness: *W. B. Brown*  
12. Signature of witness: *W. B. Brown*

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05409

Reg. Dist. No.

5418

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Breezy Point, Willows, Md.</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co Hospital</u>				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Scarp Lee Boswell</u>				4. DATE OF DEATH Month Day Year <u>5 21 1959</u>			
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/3 '96</u>		9. AGE (In years last birthday) <u>62</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Widow</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Boswell</u>				14. MOTHER'S MAIDEN NAME <u>Martha Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ethel M. Boswell</u> <u>Widow</u> <u>George Boswell</u> <u>Willows, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Diabetes Coma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dr. Jett away at time of death, who was his Dr.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. W. Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. Hugh W. Ward</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company - Washington</u>				ADDRESS <u>D.C.</u>		24a. REC'D BY REGISTRAR <u>MAY 22 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100-100

STATE OF CALIFORNIA - BATHING IS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-100

100-100



100-100



## 5419 CERTIFICATE OF DEATH

Reg. Dist. No. 05410

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick 22 hrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Brown</u>				4. DATE OF DEATH Month Day Year <u>May 12 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12, 1954</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Brown</u>				14. MOTHER'S MARDEN NAME <u>Lva Lee Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lva Lee Smith - Huntingtown, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined -</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory failure - Child apnea</u> DUE TO (c) <u>Asphyxiation, sudden / Anoxia?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>27 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>5/18</u> 19 <u>58</u> , to <u>5-13</u> 19 <u>59</u> , that I last saw the deceased alive on <u>May 13, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				DATE SIGNED <u>5/18</u>			
PHYSICIAN'S NAME (Type) <u>R. E. VILLARREAL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-14, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>lower marlboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell, Prince Frederick</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Kiana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2064181XV3



CERTIFICATE OF DEATH

218

*[Faint, mostly illegible text on the form, likely bleed-through from the reverse side. Discernible words include:]*

NAME: \_\_\_\_\_  
 SEX: \_\_\_\_\_  
 AGE: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_  
 PLACE OF BIRTH: \_\_\_\_\_  
 OCCUPATION: \_\_\_\_\_  
 CAUSE OF DEATH: \_\_\_\_\_  
 PLACE OF DEATH: \_\_\_\_\_  
 TIME OF DEATH: \_\_\_\_\_  
 SIGNATURE: \_\_\_\_\_  
 DATE: \_\_\_\_\_



## CERTIFICATE OF DEATH

Reg. Dist. No.

05411

5420

1. PLACE OF DEATH a. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Cabaret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>f</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles W. Catterton</u>				4. DATE OF DEATH Month Day Year <u>May 9 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1867</u>	9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Cabaret Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles B. Catterton</u>				14. MOTHER'S MAIDEN NAME <u>Sarah O. France</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>James W. Catterton - Lusby, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - <u>Cerebral occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. _____ Month. Day. Year 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1958</u> , to <u>May 9, 1959</u> , that I last saw the deceased alive on <u>May 9, 1959</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>R. de Villarreal</u> M.D. <u>St Leonard</u> 5/11/59 PHYSICIAN'S NAME (Type) <u>R. de VILLARREAL</u> <u>ST. LEONARD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 12, 1959</u>		<u>St. Paul's Cem.</u>		<u>Lusby - Cabaret Co - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness &amp; Son - Mutual, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 13 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**1** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 FilmG242 5-18-59 et

## 5421 CERTIFICATE OF DEATH

05412

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CALVERT</u>		MARYLAND		STATE <u>Me.</u>		COUNTY <u>ST. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PRINCE FREDERICK</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mechanicsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CALVERT Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Rural</u> <u>18X-2</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Thomas. B. DAVIS</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MAY 9 1959</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>5-12-1876</u>		<b>9. AGE last birthday</b> <u>88</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Gen. Store</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Wm J. Davis</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Turner</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hosp. Records.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>420.1 IMMEDIATE CAUSE</b> (A) <u>CORONARY OCCLUSION</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 MINUTES</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>HYPERTENSIVE C. V. Disease.</u>						<u>3 years</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO</b> (C) <u>PROSTATISM</u>						<u>?</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>21b. PLACE</b> (Home, farm, factory, or INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Dec.</u> , 19 <u>57</u> , to <u>May 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 26</u> , 19 <u>59</u> , and that death occurred at <u>                    </u> M., from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Prince Frederick</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Prince Frederick</u>		<b>DATE SIGNED</b> <u>5/9/59</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>5-12-59</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>ALL FAITH</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Charlotte Hall Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>William J. Davis</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>P. B. Robinson</u>		<b>ADDRESS</b> <u>Leonardtown Md.</u>	
<b>DATE</b> <u>MAY 12 '59</u>							

CERTIFICATE OF DEATH

DATE

20th Nov 1918

INDICATIONS

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO MAKE A MEDICAL JUDGMENT

5422 CERTIFICATE OF DEATH

Reg. Dist. No.

05413

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Cabot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Huntingtown</u>			
c. LENGTH OF STAY IN lb <u>3 yrs</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Livings Rest Home</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE W. DORSEY</u>				4. DATE OF DEATH Month Day Year <u>May 2 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25, 1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Finance Officer</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Ward</u>				14. MOTHER'S MAIDEN NAME <u>Belle Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Frank Dorsey - Huntingtown, Ind</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-10</u> 19 <u>58</u> , to <u>2 May</u> 19 <u>59</u> , that I last saw the deceased alive on <u>May 1</u> 19 <u>59</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. J. Weems</u>				ADDRESS (Street, city or town, state) <u>Huntingtown, Ind</u> DATE SIGNED <u>5/4/59</u>			
PHYSICIAN'S NAME (Type) <u>G. J. WEEMS</u>				HUNTINGTOWN, IND.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 5, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Plum Point - Cabot Co - Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. D. Harkness &amp; Son - Mutual, Ind.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE MAY 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kame</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

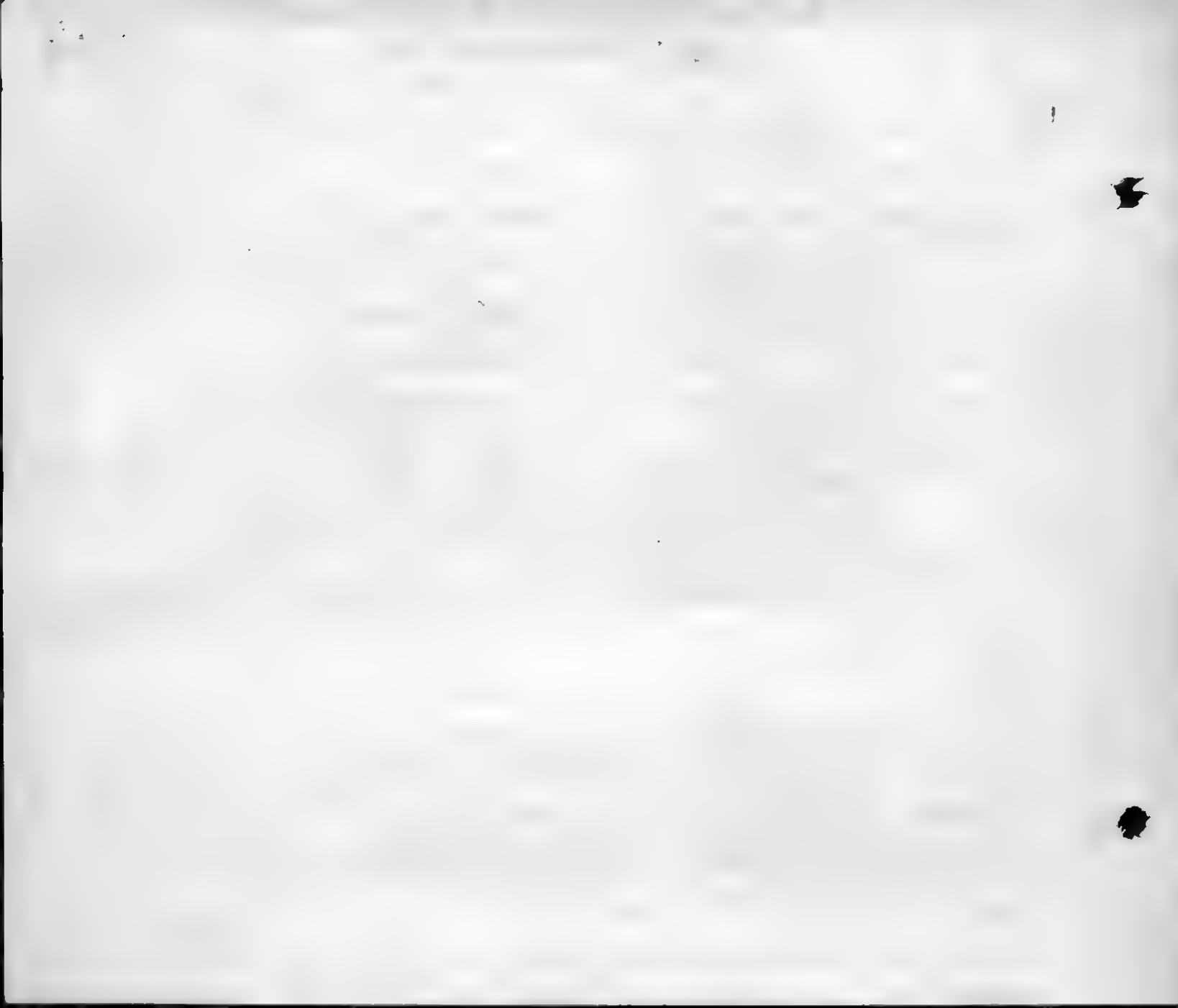
# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 5423 CERTIFICATE OF DEATH

Reg. Dist. No. 05414

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>md.</u> c. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Dowell</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gross</u>		4. DATE OF DEATH Month Day Year <u>5</u> <u>11</u> <u>1959</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/12/59</u>
9. AGE (In years last birthday) yrs. <u>8</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>P</u>		14. MOTHER'S MAIDEN NAME <u>Lorraine Gross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Lorraine Gross</u>		Address <u>Dowell, md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO <u>(No prenatal care)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(b)</u> DUE TO (c) <u>(c)</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 11</u> , 19 <u>59</u> , to <u>May 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/12</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R de Vicca</u>		ADDRESS (Street, city or town, state) <u>St Leonard</u> DATE SIGNED <u>5/12/59</u>	
PHYSICIAN'S NAME (Type) <u>R de Vicca</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Johns</u>	22d. LOCATION (City, town, or county) (State) <u>md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Prince Fred,</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 14 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	





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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5424

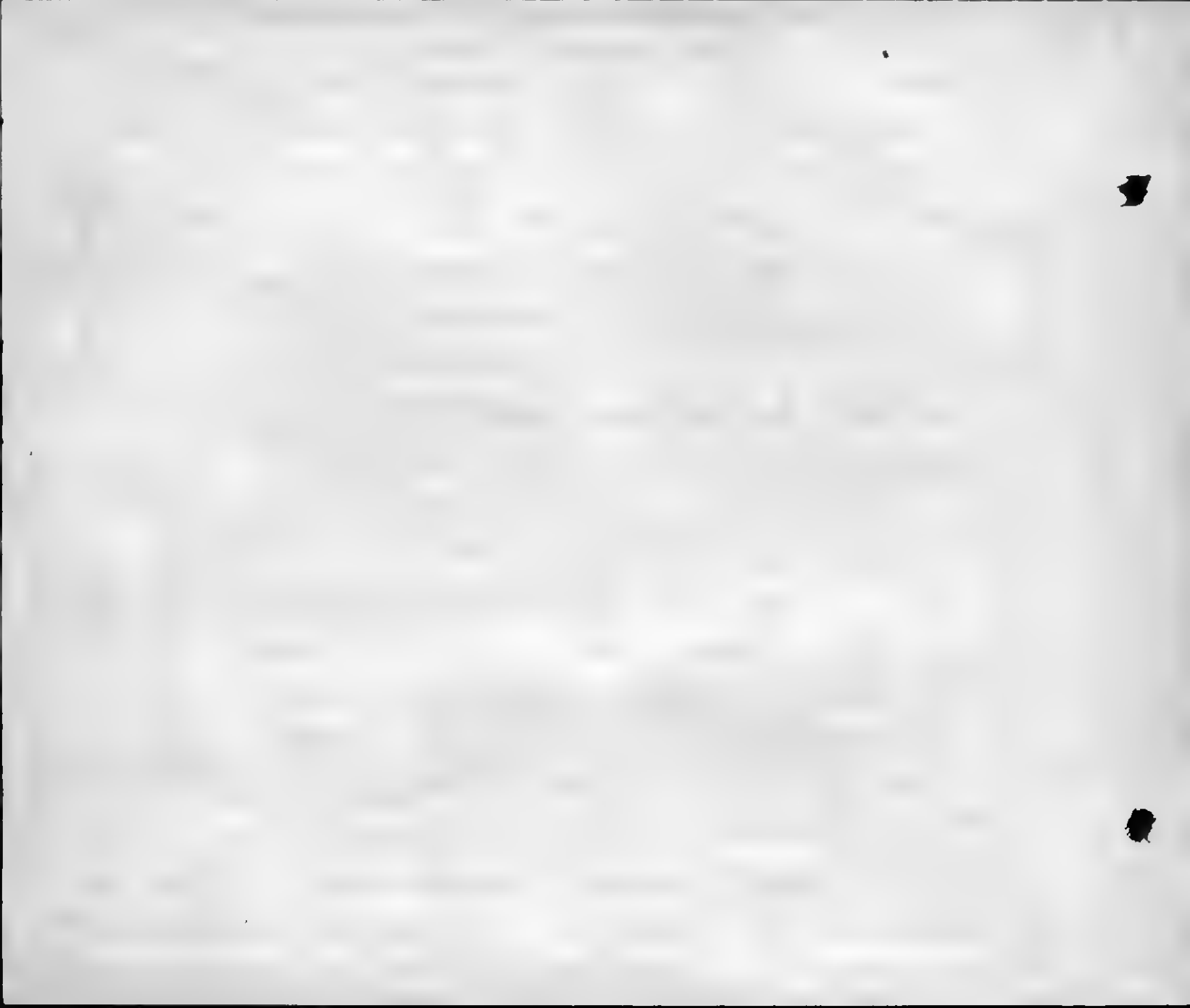
CERTIFICATE OF DEATH

05415

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonards Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonards Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Jane</u> Last <u>Gross</u>				4. DATE DEATH Month <u>5</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 7, 1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>59</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>59</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Hooker</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Murnay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>George Gross St. Leonards Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> <u>420.1</u> DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(Sudden death)</u> DUE TO (c) <u>(Sudden death)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Devillacreal</u> M.D. <u>St. Leonards Md</u>				DATE SIGNED <u>5/2</u>			
PHYSICIAN'S NAME (Type) <u>R. Devillacreal</u>							
22a. (BURIAL) CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-5-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Island Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>P. E. Sewell Prima Frederick</u>				24a. REC'D BY REGISTRAR <u>MAY 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

5425

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u> c. LENGTH OF STAY IN TB <u>10 Mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cabot St. Leonard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cabot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Leonard</u> d. STREET ADDRESS <u>St. Leonard</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard G. Gutmann</u> First Middle Last		4. DATE OF DEATH Month <u>5</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/16/186</u> 9. AGE (In years and birthday) <u>13</u> yrs. IF UNDER 1 YEAR: Months <u>13</u> Days <u>16</u> IF UNDER 24 HRS. Hours <u>16</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baker</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lawrence Gutmann</u>		14. MOTHER'S MAIDEN NAME <u>Frieda Hecken</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Wm. Mary Gutmann</u>		Address <u>St. Leonard</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Renal disease</u> DUE TO (c) <u>Fracture neck about 1 yr ago</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture neck 1 yr ago and has been without</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>1 yr</u> <u>1 yr</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Limit space to injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> a. m. <u>16</u> p. m. <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>St. Leonard</u> (County) <u>Calvert</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>May 19, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Solomon Catholic Cem.</u>		22d. LOCATION (City, town, or county) <u>St. Leonard</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>O. R. Harkness &amp; Son - Mutual, Inc.</u>		24a. REC'D BY REGISTRAR <u>May 19 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

5/16/59





## 5426 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>HERMAN ORDMAN HUGHES</i>		4. DATE OF DEATH Month Day Year <i>May 5 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 31, 1883</i>
9. AGE (In years last birthday) <i>75 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Eugene Hughes</i>		14. MOTHER'S MAIDEN NAME <i>Emma Ordeman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Mrs. F. D. Chappelle, Hughesville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>aspiration pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Carcinoma of Esophagus</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i> <i>8 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/27</i> 19 <i>59</i> , to <i>5/5</i> 19 <i>59</i> , that I last saw the deceased alive on <i>5/5</i> 19 <i>59</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul H. Tett</i>		M. D. <i>Prince Frederick</i>	
PHYSICIAN'S NAME (Type) <i>PAUL H. TETT</i>		DATE SIGNED <i>PRINCE FREDRICK</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>5/7/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Company</i>		24. REG'D BY REGISTRAR <i>2901 14th St. N.W. Washington 9, D.C. MAY 7 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5427 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>17 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jones</u>		4. DATE OF DEATH Month Day Year <u>May 4 1959</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/3/59</u>
9. AGE (In years last birthday) <u>17</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lloyd Edwin Jones</u>		14. MOTHER'S MAIDEN NAME <u>Carlise Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Carlise Jones, Huntingtown, Md.</u>	
17. INFORMANT <u>Carlise Jones, Huntingtown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Be mature</u> DUE TO <u>116X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 3</u> , 19 <u>55</u> , to <u>May 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>59</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u>		M. D.	
PHYSICIAN'S NAME (Type) <u>Dr. George J. Weems</u>		<u>Huntingtown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-5-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Private lot</u>	22d. LOCATION (City, town, or county) (State) <u>Huntingtown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lloyd E. Jones - Huntingtown, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>5/19/59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MORTAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5428

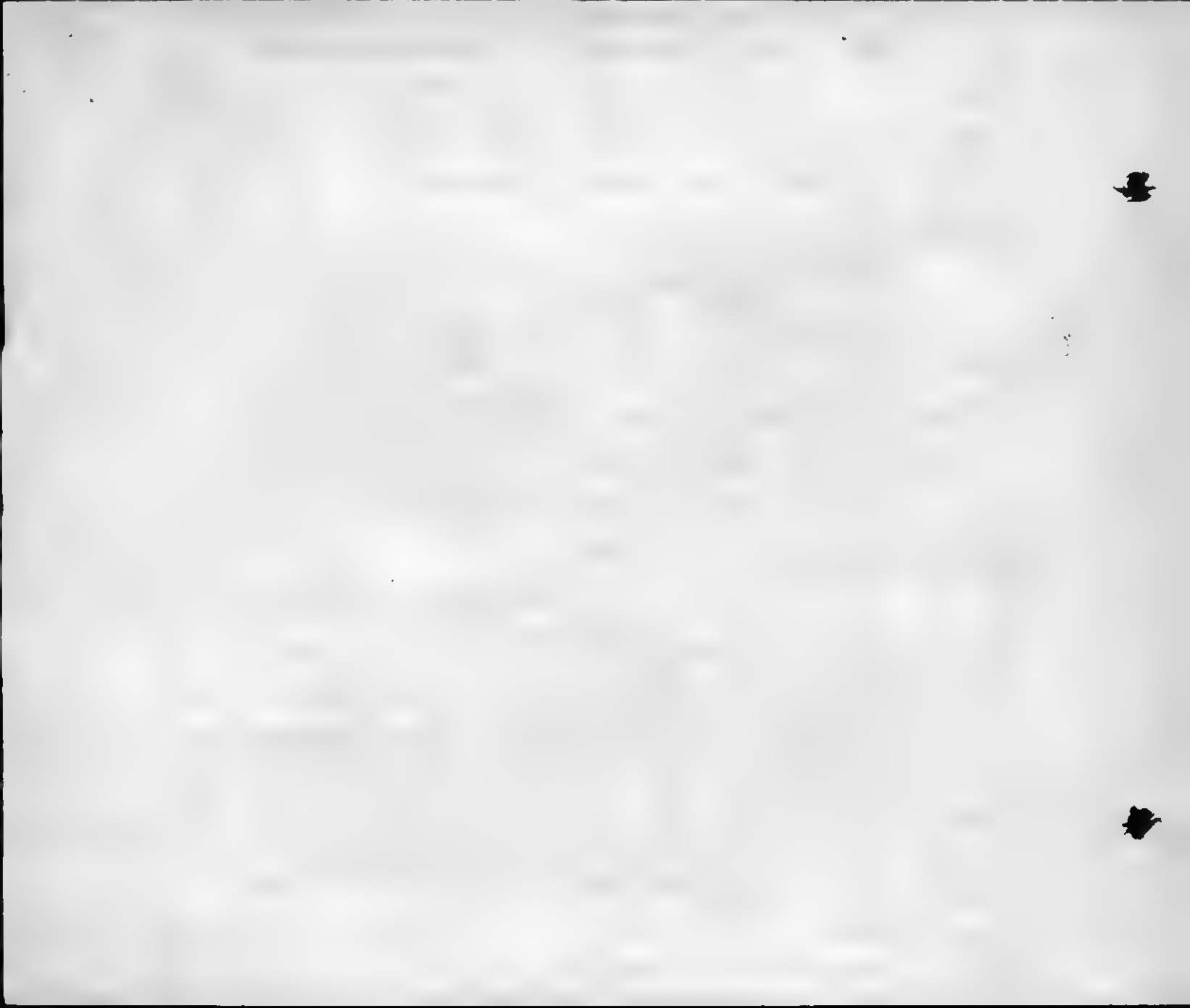
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owney Md</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>Owney Md</u>	
3. NAME OF DECEASED (Type or print) <u>Adie</u> First Middle Last		4. DATE OF DEATH Month <u>5</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 2 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wesley Kent</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kent</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Adie Kent</u> Address <u>Owney Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in house</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>5/13/59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Owney Calvert Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Way of the Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Sunderland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell Prince Frederick</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 20 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

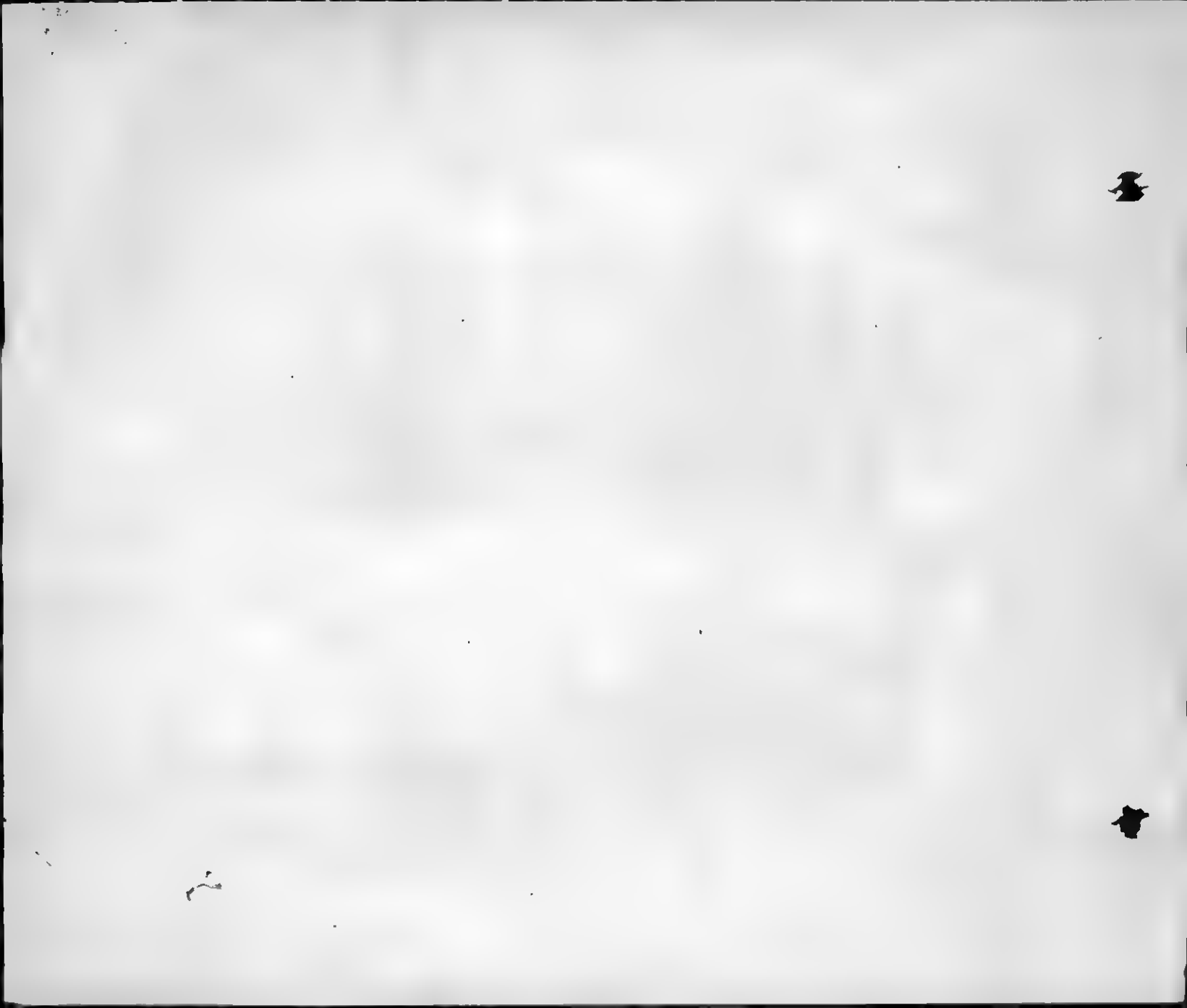
5429

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05420

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fusby Md</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MARTHA ELIZABETH LEQUESNE</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fusby</u> d. STREET ADDRESS <u>LEQUESNE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Lequesne</u> First <u>Elizabeth</u> Middle <u>Lequesne</u> Last <u>Lequesne</u>		4. DATE OF DEATH <u>5</u> Month <u>14</u> Day <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/8/71</u>	9. AGE (In years, months, days, hours, minutes) <u>87</u> yrs. <u>8</u> months <u>14</u> days <u>19</u> hours <u>59</u> minutes	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Church Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTH PLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Joseph A. Lequesne</u>		14. MOTHER'S MAIDEN NAME <u>Martha Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Hospital Chart</u> Address <u>816 W. McFadden</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>704.0</u> DUE TO <u>Fall 4/8/59</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Age</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been doing OK until 5/15/59. Vandy &amp; discharge</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home and was found 3 hrs later</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> a. m. <u>4/8/59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. City or town <u>Fusby</u>		20g. County <u>Calvert</u>		20h. State <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5/14/59</u>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 16, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MIDDLEHAM CHAPEL</u>	
22d. LOCATION (City, town, or county) <u>LUSBY - CALVERT CO - MD.</u>		(State) <u>MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. O. Harkness &amp; Son - Mutual, Md</u>		ADDRESS <u>4100 S. E. Howard</u>		24a. REC'D BY REGISTRAR <u>MAY 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 FilmG242 5-18-59 et

05421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Fredrick</u> c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cabot Co. Mary Ann Home</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>3V01-4</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1100 Forrest Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Dean</u> First Middle Last 4. DATE OF DEATH <u>5</u> Month <u>12</u> Day <u>1959</u> Year		5. SEX <u>7</u> 6. COLOR OF RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 13, 1877</u> 9. AGE (In years (by birthday) yrs. <u>81</u> Months <u>5</u> Days <u>12</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Va.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles W. Sheetz</u> 14. MOTHER'S MAIDEN NAME <u>Lucinda (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Thomas Riddleberger, 1100 Forrest Street</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary embolism</u> 467.2 DUE TO <u>subcutaneous hemorrhages</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 yrs</u> DUE TO (c) <u>2 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was gay to bathroom and fell dead in floor</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>12/12/59</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Prince Fredrick</u> (County) <u>Cabot</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>HW Ward</u> EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> 22b. DATE THEREOF <u>5-14-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u> 22d. LOCATION (City, town, or county) <u>Martinsburg, W. Va.</u> (State)		24a. REC'D BY REGISTRAR <u>MAY 14 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u> ADDRESS			

10-15-30

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of death: 10-15-30

5. Place of death: Home

6. Cause of death: Heart Disease

7. Manner of death: Natural

8. Signature of Medical Examiner: [Signature]

9. Date of signature: 10-15-30

10. Name of Coroner: [Signature]

11. Date of signature: 10-15-30

12. Name of Registrar: [Signature]

13. Date of signature: 10-15-30



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5431 CERTIFICATE OF DEATH

05422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Webster</u>				4. DATE OF DEATH Month Day Year <u>May 20 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 23, 1875</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MACHINIST</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Daniel Webster</u>		14. MOTHER'S MAIDEN NAME <u>Isabella Webster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT Address <u>Margaret Webster, St. Leonard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>5/12</u> , 19 <u>59</u> , to <u>5/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>59</u> , and that death occurred at <u>12:10</u> A. M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>S. J. Henman</u> ADDRESS (Street, city or town, state) <u>St. Leonard, Md.</u> DATE SIGNED <u>5/20</u> PHYSICIAN'S NAME (Type) <u>Dr. Roberto de Villarreal</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Seagrave-Washington Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u>				ADDRESS <u>3821-14th St. N. W.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

10-183

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

1931

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

Vertical text on the right margin, likely a filing or archival note.